AMENDED IN ASSEMBLY MAY 26, 2000

AMENDED IN ASSEMBLY MAY 17, 2000

AMENDED IN ASSEMBLY APRIL 24, 2000

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL No. 2265

Introduced by Assembly Member Aroner
(Coauthors: Assembly Members Alquist, Cedillo, and Thomson)

February 24, 2000

An act to amend Section 1368.2 of, and to add Sections 1746.5 and 1746.6 to, the Health and Safety Code, to amend Section 10232.9 of the Insurance Code, and to amend Section 14132 of the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

AB 2265, as amended, Aroner. End-of-life care.

Existing law provides for the licensure and regulation by the State Department of Health Services of persons or agencies providing hospice services for persons, and the families of persons, who are experiencing the last phases of life due to a terminal disease.

Existing law requires every health care service plan, other than specialized plans, to provide coverage for hospice care, commencing January 1, 2002.

Existing law requires long-term care policies that provide benefits of home care or community-based services also to provide coverage for hospice care.

Existing law also provides that hospice care is a covered benefit under the Medi-Cal program.

This bill would, for purposes of the above-mentioned provisions of law, require that palliative care consultations consisting of specified services be provided to patients and their families when the patients have a limited life expectancy due to a terminal illness. It would further require that these consultations be provided by physicians or licensed certified hospice providers prior to the decision to elect hospice care.

Existing definitions contained in hospice program licensing provisions are applicable to health care service plan provisions.

This bill would also apply these definitions to long-term care insurance policy and Medi-Cal program provisions.

Because violation of hospice program licensing provisions and willful violation of health care service plan provisions is a crime, the bill would constitute a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares that an important component of hospice care and end-of-life care provided in any health facility or at home includes valuable and time-consuming discussions with the dying patient and his or her family members.

(b) It is the intent of the Legislature that, prior to the election of hospice care, ~~end of life~~ *end-of-life* options be presented and discussed with patients who have a limited life expectancy and their families. The Legislature finds and declares that these palliative care consultations by physicians or licensed certified hospice programs

represent a range of important information that should be available to dying patients and their families, whatever the means of health insurance and health provider, whether it is through health care service plans, long-term care health insurance, or Medi-Cal.

SEC. 2. Section 1368.2 of the Health and Safety Code is amended to read:

1368.2. (a) On and after January 1, 2002, every group health care service plan contract, except a specialized health care service plan contract, which is issued, amended, or renewed, shall include a provision for hospice care.

(b) The hospice care shall at a minimum be equivalent to hospice care provided by the federal Medicare program pursuant to Title XVIII of the Social Security Act.

(c) The following are applicable to this section and to paragraph (7) of subdivision (b) of Section 1345:

(1) The definitions in Section 1746.

(2) The ''federal regulations'' which means the regulations adopted for hospice care under Title XVIII of the Social Security Act in Title 42 of the Code of Federal Regulations, Chapter IV, Part 418, except Subparts A, B, G, and H, and any amendments or successor provisions thereto.

(d) The commissioner no later than January 1, 2001, shall adopt regulations to implement this section. The regulations shall meet all of the following requirements:

(1) Be consistent with all material elements of the federal regulations that are not by their terms applicable only to eligible Medicare beneficiaries. If there is a conflict between a federal regulation and any state regulation, other than those adopted pursuant to this section, the commissioner shall adopt the regulation that is most favorable for plan subscribers, members or enrollees to receive hospice care.

(2) Be consistent with any other applicable federal or state laws.

(3) Be consistent with the definitions of Section 1746.

(e) This section is not applicable to the subscribers, members, or enrollees of a health care service plan who elect to receive hospice care under the Medicare program.

(f) The commissioner, commencing on January 15, 2002, and on each January 15th thereafter, shall report to the Health Care Service Plan Advisory Committee any changes in the federal regulations that differ materially from the regulations then in effect for this section. The commissioner shall include with the report written text for proposed changes to the regulations then in effect for this section needed to meet the requirements of subdivision (d).

(g) Palliative care consultations shall be provided to patients and their families when the patients have a limited life expectancy due to a terminal illness. These palliative care consultations shall be provided by physicians or licensed certified hospice providers prior to the decision to elect hospice care. Palliative care consultations shall consist of patient and family education relating to the last phases of life, including, but not limited to, pain and symptom management, psychosocial and spiritual issues, and advising family members that they may need professional services related to legal and other family obligations associated with the end of life, but that these services are not covered by hospice benefits.

SEC. 3. Section 1746.5 is added to the Health and Safety Code, to read:

1746.5. Palliative care consultations shall be provided to patients and their families when the patients have a limited life expectancy due to a terminal illness. These palliative care consultations shall be provided by physicians or licensed certified hospice providers prior to the decision to elect hospice care. Palliative care consultations shall consist of patient and family education relating to the last phases of life, including, but not limited to, pain and symptom management, psychosocial and spiritual issues, and advising family members that they may need professional services related to legal and other

family obligations associated with the end of life, but that these services are not covered by hospice benefits.

SEC. 4. Section 1746.6 is added to the Health and Safety Code, to read:

1746.6. Palliative care consultations for a patient and his or her family members regarding the services associated with a hospice program prior to the patient choosing to enroll or enter a hospice program in the state, shall not be deemed a potential fraud or abuse practice. A hospice program may counsel a patient and his or her family members prior to enrollment or entrance into a hospice program as long as the hospice program is assisting the patient and his or her family members in understanding the components of palliative care. A solicitation by a particular hospice program to a patient or his or her family member for the sole purpose of enrolling or entering a patient is not a palliative care consultation.

SEC. 5. Section 10232.9 of the Insurance Code is amended to read:

10232.9. (a) Every long-term care policy or certificate that purports to provide benefits of home care or community-based services, shall provide at least the following:

(1) Home health care.

(2) Adult day care.

(3) Personal care.

(4) Homemaker services.

(5) Hospice services.

(6) Respite care.

(b) For purposes of this section, policy definitions of these benefits may be no more restrictive than the following:

(1) ‘‘Home health care’’ is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

(2) ‘‘Adult day care’’ is medical or nonmedical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.

(3) ‘‘Personal care’’ is assistance with the activities of daily living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction. ‘‘Instrumental activities of daily living’’ include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

(4) ‘‘Homemaker services’’ is assistance with activities necessary to or consistent with the insured’s ability to remain in his or her residence, that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.

(5) ‘‘Hospice services’’ are those services described in Section 1746 of the Health and Safety Code that are not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal condition, and to provide supportive care to the primary caregiver and the family. Palliative care consultations shall be provided to patients and their families when the patients have a limited life expectancy due to a terminal illness. These palliative care consultations shall be provided by physicians or licensed certified hospice providers prior to the decision to elect hospice care. Palliative care consultations shall consist of patient and family education relating to the last phases of life, including, but not limited to, pain and symptom management, psychosocial and spiritual issues, and advising family members that they may need professional services related to legal and other

family obligations associated with the end of life, but that these services are not covered by hospice benefits. Care may be provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction. For policies that are intended to be federally qualified long-term care insurance contracts, as defined in Section 10232.1, hospice services shall be covered to the extent authorized under Public Law 104-191, and regulations adopted thereunder.

(6) ''Respite care'' is short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary caregiver in the home. This is a separate benefit with its own conditions for eligibility and maximum benefit levels.

(c) Home care benefits shall not be limited or excluded by any of the following:

(1) Requiring a need for care in a nursing home if home care services are not provided.

(2) Requiring that skilled nursing or therapeutic services be used before or with unskilled services.

(3) Requiring the existence of an acute condition.

(4) Limiting benefits to services provided by Medicare-certified providers or agencies.

(5) Limiting benefits to those provided by licensed or skilled personnel when other providers could provide the service, except where prior certification or licensure is required by state law.

(6) Defining an eligible provider in a manner that is more restrictive than that used to license that provider by the state where the service is provided.

(7) Requiring ''medical necessity'' or similar standard as a criteria for benefits.

(d) Every comprehensive long-term care policy or certificate that provides for both institutional care and home care and that sets a daily, weekly, or monthly benefit payment maximum, shall pay a maximum benefit payment for home care that is at least 50 percent of the maximum benefit payment for institutional care, and in no event shall home care benefits be paid at a rate less

than fifty dollars ($50) per day. Insurance products approved for residents in continuing care retirement communities are exempt from this provision.

Every such comprehensive long-term care policy or certificate that sets a durational maximum for institutional care, limiting the length of time that benefits may be received during the life of the policy or certificate, shall allow a similar durational maximum for home care that is at least one-half of the length of time allowed for institutional care.

SEC. 6. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy and occupational therapy, are covered subject to utilization controls.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

(d) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetists services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. The department's utilization controls shall not require X-rays as a condition of reimbursement for fillings for children under 18 years of age. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions which preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the

modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(n) Family planning services are covered, subject to utilization controls.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, other prophylaxis treatment for children 17 years of age and under, are covered.

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are

necessary services provided by a registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, ‘‘in-home medical care service’’ includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services, include, but are not limited to:

(1) Level of care and cost of care evaluations.

(2) Expenses, directly attributable to home care activities, for materials.

(3) Physician fees for home visits.

(4) Expenses directly attributable to home care activities for shelter and modification to shelter.

(5) Expenses directly attributable to additional costs of special diets, including tube feeding.

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

(9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.

(15) Special drugs and medications.

(16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.

(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.

(19) Modification of medical equipment for home use.

(20) Training and orientation for use of life support systems, including, but not limited to, support of respiratory functions.

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is

available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

The department shall submit a report, as provided in Section 28 of the 1982 Budget Act, 30 days prior to providing these services as Medi-Cal benefits. The report shall be submitted to the Joint Legislative Budget Committee and the fiscal committees and shall address the cost effectiveness of services provided pursuant to this subdivision.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter

XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service, as defined in Section 1746 of the Health and Safety Code, that is provided by a Medicare-certified hospice service, is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred. Palliative care consultations shall be provided to patients and their families when the patients have a limited life expectancy due to a terminal illness. These palliative care consultations shall be provided by physicians or licensed certified hospice providers prior to the decision to elect hospice care. Palliative care consultations shall consist of patient and family education relating to the last phases of life, including, but not limited to, pain and symptom management, psychosocial and spiritual issues, and advising family members that they may need professional services related to legal and other family obligations associated with the end of life, but that these services are not covered by hospice benefits.

(x) When a claim for treatment provided to a beneficiary includes both services which are authorized and reimbursable under this chapter, and services which are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in

accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program.

(2) The department shall seek a waiver for a program to provide comprehensive clinical family planning services as described in paragraph (8). The program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. The services shall be provided under the program only if the waiver is approved by the federal Health Care Financing Administration in accordance with Section 1396n of Title 42 of the United States Code and only to the extent that federal financial participation is available for the services.

(3) Solely for the purposes of the waiver and notwithstanding any other provision of law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for

under this subdivision. No other provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Health Care Financing Administration and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) is no longer cost-effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under

the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, ‘‘comprehensive clinical family planning services’’ means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty

for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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